Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
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Submission Date:	September 21, 2007

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
The Alabama Medicaid Agency is requesting a five year renewal of the Home and Community Based Waiver for the Elderly and Disabled Waiver #0068.91.R4.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

1. Request Information

A. The **State** of **Alabama** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Elderly and Disabled Waiver

C. Type of Request *(select only one)*:

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	0068.91.R4	
O	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

O	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: October 1, 2007

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	O	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	O	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	O	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Elderly and Disabled Waiver Program is to provide home and community-based services to elderly and disabled individuals in the community who would otherwise require nursing facility care. The waiver is aimed at providing quality and cost-effective services to individuals at risk of institutional care. The AMA serves as the administering agency for this program and the two operating agencies are the Alabama Department of Public Health and the Alabama Department of Senior Services. The operating agencies are responsible for the day-to-day operations of the program. This includes managing the program by focusing on improving care for the client, protecting the health and welfare of the client, giving the client free choice of providers and waiver services workers, and making sure all direct service providers meet the qualifications. Anyone interested in waiver services should contact one of the operating agencies. The services provided under this waiver are case management, personal care, homemaker services, respite care (skilled and unskilled), companion services, adult day health and home delivered meals. The goal of the waiver is to help recipients receive services not ordinarily covered by Medicaid under the State Plan.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

O	The waiver provides for participant direction of services. *Appendix E is required.*
X	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

O	Yes
X	No
O	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

During the course of this waiver period no further requests for changes have been received from the public. Recipient comments are gathered by the AMA Quality Improvement Standards Division and are given serious consideration in developing waiver improvements.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60

days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Latonda
Last Name	Cunningham
Title:	Administrator
Agency:	Alabama Medicaid Agency
Address 1:	501 Dexter Avenue
Address 2:	
City	Montgomery
State	Alabama
Zip Code	36103
Telephone:	334-353-4122
E-mail	Latonda.Cunningham@medicaid.alabama.gov
Fax Number	334-353-4182

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Carol H.
Last Name	Steckel
Title:	Commissioner
Agency:	Alabama Medicaid Agency
Address 1:	501 Dexter Avenue
Address 2:	
City	Montgomery
State	Alabama
Zip Code	36103
Telephone:	334-242-5600
E-mail	Carol.Steckel@medicaid.alabama.gov
Fax Number	334-242-5097

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	○ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)
X	The waiver is operated by **Alabama Department of Public Health (ADPH) and Alabama Department of Senior Services (ADSS)** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Elderly and Disabled Waiver (E&D) is administered by the Long Term Care Division of the Alabama Medicaid Agency (AMA) and operated by ADPH and ADSS. The AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. The AMA assumes the responsibility of: (1) Conducting joint trainings with direct service providers enrolled to provide services through the Elderly and Disabled waiver program; (2) Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the E&D Waiver program, which are outlined in the E&D Waiver manual, (3) Conducts annual training to disseminate policies, rules and regulations regarding the home and community-based waiver programs and, (4) signs all qualified direct service providers contracts enrolled with ADPH and ADSS to provide waiver services.

The State AMA Quality Improvement (QI) and Standards Division has developed a Quality Management Strategy for the E&D Waiver Program. The following activities are components of the Quality Assurance Strategy: (1) Collect ongoing monthly data to monitor appropriateness of level of care determinations; (2) Collect quarterly data from registered nurses by either/or reviewing a sample of waiver case management records, direct service provider records, conducting on-site visits to participant's homes, conduct consumer satisfactions surveys and tracking complaints and grievances; (3) Identify remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction with 15 days of notification. If non-compliance is not resolved, the entity will be monitored every three months until compliance is achieved; and (4) Collect data and submit quarterly and annual reports from the Department of Public Health, Department of Senior Services and AMA staff for evaluation and recommendations for program improvements.

The AMA Quality Improvement (QI) and Standards Division also mail satisfaction surveys quarterly to clients, and tracks any complaints and grievances that are received.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
X	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
X	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	X	☐	☐
Assist individuals in waiver enrollment	☐	X	☐	☐
Manage waiver enrollment against approved limits	X	X	☐	☐
Monitor waiver expenditures against approved levels	X	X	☐	☐
Conduct level of care evaluation activities	☐	X	☐	☐
Review participant service plans to ensure that waiver requirements are met	X	X	☐	☐
Perform prior authorization of waiver services	☐	☐	☐	☐
Conduct utilization management functions	X	X	☐	☐
Recruit providers	X	X	☐	☐
Execute the Medicaid provider agreement	X	X	☐	☐
Determine waiver payment amounts or rates	X	X	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	X	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group		Target Group/Subgroup	Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
X	**Aged or Disabled, or Both** *(select one)*				
	X	**Aged or Disabled or Both – General** *(check each that applies)*			
	X	Aged (age 65 and older)	0		X
	X	Disabled (Physical) (under age 65)	0		
	X	Disabled (Other) (under age 65)	0		
	○	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The E&D Waiver requires all clients to meet the nursing facility level of care.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

X	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	○ [ ] %, a level higher than 100% of the institutional average
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ [ ]
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: [ ] %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	9205
Year 2	9205
Year 3	9205
Year 4 (renewal only)	9205
Year 5 (renewal only)	9205

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

X	The State does not limit the number of participants that it serves at any point in time during a waiver year.
O	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

X	**Not applicable**. The state does not reserve capacity.
O	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
O	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

X	Waiver capacity is allocated/managed on a statewide basis.
O	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the waiver is prioritized based on the imminent need for services that is determined through an assessment process or on the date of application or referral.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

X	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
☐	Low income families with children as provided in §1931 of the Act			
X	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
X	Optional State supplement recipients			
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	○	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
☐	Medically needy			
X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
	Individuals deemed eligible for SSI under 42 CFR 435.122, 435.134, 435.135, 435.137, 435.138, Section 6 of Public Law 99-643, and individuals eligible under 42 CFR 435.145 and 435.227.			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*			

		All individuals in the special home and community-based waiver group under 42 CFR §435.217				
	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
		X	A special income level equal to (select one):			
			X	300% of the SSI Federal Benefit Rate (FBR)		
			○	100 %	of FBR, which is lower than 300% (42 CFR §435.236)	
			○	$	which is lower than 300%	
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
		☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
		☐	Aged and disabled individuals who have income at: *(select one)*			
			○	100% of FPL		
			○	%	of FPL, which is lower than 100%	
			Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

○	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	○ Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
X	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
X	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%		of the Federal poverty level
	X	Other (specify):		
		The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust.		

O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

O	SSI standard		
O	Optional State supplement standard		
O	Medically needy income standard		
O	The following dollar amount:	$	If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
X	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

O	AFDC need standard		
O	Medically needy income standard		
O	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
O	The amount is determined using the following formula:		
O	Other (specify):		
X	Not applicable *(see instructions)*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

	Not applicable *(see instructions)*
X	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ☐ The following standard included under the State plan *(select one)*
- ☐ The following standard under 42 CFR §435.121:
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons *(select one)*
  - ☐ 300% of the SSI Federal Benefit Rate (FBR)
  - ☐ % of the FBR, which is less than 300%
  - ☐ $ which is less than 300% of the FBR
- ☐ % of the Federal poverty level
- ☐ Other (specify):
- ☐ The following dollar amount: $ If this amount changes, this item will be revised.
- ☐ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ☐ The following standard under 42 CFR §435.121
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☐ The following dollar amount: $ If this amount changes, this item will be revised.
- ☐ The amount is determined using the following formula:
- ☐ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ☐ AFDC need standard
- ☐ Medically needy income standard

○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	Not applicable *(see instructions)*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- [ ] The following standard included under the State plan *(select one)*
  - [ ] SSI standard
  - [ ] Optional State supplement standard
  - [ ] Medically needy income standard
  - [ ] The special income level for institutionalized persons *(select one):*
    - [ ] 300% of the SSI Federal Benefit Rate (FBR)
    - [ ] ____ % of the FBR, which is less than 300%
    - [ ] $ ____ which is less than 300%.
  - [ ] ____ % of the Federal poverty level
  - [ ] Other (specify):
- [ ] The following dollar amount: $ ____ If this amount changes, this item will be revised.
- [ ] The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- [ ] The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - [ ] SSI standard
  - [ ] Optional State supplement standard
  - [ ] Medically needy income standard
  - [ ] The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - [ ] The amount is determined using the following formula:
- [ ] Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other *(specify)*:
	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	Not applicable *(see instructions)*
	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	

		Other (specify):
○	The following dollar amount:	$ If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:	

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
	○	The following standard under 42 CFR §435.121:
	○	Optional State supplement standard
	○	Medically needy income standard
	○	The following dollar amount: $ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:
○	Not applicable *(see instructions)*	

iii. Allowance for the family *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	Not applicable *(see instructions)*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**	
○	SSI Standard
○	Optional State Supplement standard
○	Medically Needy Income Standard
○	The special income level for institutionalized persons
○	% of the Federal Poverty Level
○	The following dollar amount: $ If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:
○	Other (*specify*)**:**
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
○	Allowance is the same
○	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	Not applicable *(see instructions)*
○	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	One	
ii.	**Frequency of services**. The State requires *(select one)*:	
	○	The provision of waiver services at least monthly
	X	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
		All clients are monitored through at least one monthly face-to-face visit by the case manager only. The monthly face-to-face visit is the minimum monthly contact. Monitoring of participants is conducted more frequently if there is a change in the participant's medical condition or if there is a change in the participant's environmental circumstances. The frequency of other waiver services is determined by the physician based upon the needs of the waiver participant and is specified on the participant's individual plan of care.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
X	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The OA have Nurse Consultants on staff that perform the initial evaluations. They are Registered Nurses with a State of Alabama license.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The E&D Waiver recipients must meet the nursing facility level of care. The tool used to determine the NF LOC is the Alabama Home and Community Based Services Program Assessment (HCBS-1) form. New admissions must meet two of the criteria listed in A-J while a re-admission must meet only one of the criteria listed in A-J. Supporting documentation must be submitted with the application.

The admission criteria is as follows:

A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment.

B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.

C. Nasopharyngeal aspiration required for the maintenance of a clear airway.

D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.

E. Administration of tube feedings by naso-gastric tube.

F. Care of extensive decubitus ulcers or other widespread skin disorders.

G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.

H. Use of oxygen on a regular or continuing basis.

I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.

J. Comatose client receiving routine medical treatment.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Waiver applicants for whom there is a reasonable indication that services may be needed in the future are provided an individual Level of Care (LOC) evaluation. The case managers submit a Home and Community Based Waiver (HCBS-1) application to the nurse reviewer on staff at the Operating Agencies to evaluate and make the level of care determination. The nurse reviewers evaluate the application to make sure it is complete, supports the need for waivers services, establishes the risk of nursing home placement and the medical criteria is met and level of care is approved. The approval of the appropriateness of admission or continued eligibility is assessed from the documentation as per the HCBS-1 assessment tool and other documents which may include physician progress notes, and/or hospital records. A review not only includes meeting the level of care criteria as developed by the Alabama Medicaid Agency but also the assessment of the support systems within the home, the functional limitations of the recipient, the diagnosis and any factors that would place the recipient at risk of institutionalization. Medicaid may also assist with difficult LOC evaluations.

Once the application is approved it's entered electronically into the EDS/Medicaid system. If no problems are identified, EDS enters the approval in the AMA Long Term Care file and writes a waiver eligibility segment indicating the beginning and ending eligibility dates. Verification and acceptance will be returned overnight to ADPH and ADSS.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

O	Every three months
O	Every six months
X	Every twelve months
	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

Reevaluations of eligibility for the E&D Waiver must be completed every twelve months. This process is the same as the initial application packet which includes a new level of care, and plan of care. Reevaluations must be done on a timely basis so that services and payment will not be interrupted. Billing for Waiver services is bounced against the Waiver Service Long Term Care

Benefit Plan, and if eligibility for Waiver Services is current, the claim is paid. If the reevaluation has not been accomplished in a timely manner and the eligibility is not current, the claim will deny. The Alabama Medicaid Agency will not back date reevaluations not received in a timely manner.

The case managers review the client's records monthly to determine the need for waiver services. Case Managers also keep a copy of the client's reevaluation dates in a tickler file to ensure timely re-evaluations are accomplished.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and reevaluations are maintained for a minimum period of 3 years. The clients records are located at:

1. Direct Service Providers
2. Operating Agency Case Record

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Freedom of Choice: being informed of feasible alternatives under the waiver.

As part of the assessment and service coordination visit, clients and/or responsible parties are provided with adequate information to make an informed decision as to where the client's care will be received. Service coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the client, both formal and informal, as well as those waiver services which may be available to meet the client's needs and those needs which cannot be met.

Freedom of Choice: being given the choice of either institutional or home and community based services.

Each waiver client must make a written choice for either institution or community care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager. A responsible party should be encouraged to assume responsibility for working with the case manager in arranging for an appropriate plan of care. This may include the responsible party signing the forms.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The forms are maintained in the Operating Agency Case Record.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Accommodations made for Limited English Proficiency (LEP) persons include a language line as well as several publications in Spanish on the Medicaid Website such as the Covered Services Handbook, and basic eligibility documents. The language translation line offers numerous languages and meaningful access through the Medicaid toll free telephone number. Through the translators the LEP person can request and receive any available Medicaid assistance and apply for available Medicaid services. Hispanic is the only significant Limited English proficiency population in the State of Alabama at 1.7%.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	X	
Homemaker	X	
Home Health Aide	☐	
Personal Care	X	
Adult Day Health	X	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	X	Skilled and Unskilled
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	
Companion Services	X	
Home Delivered Meals	X	Breakfast; Shelf Stable and Frozen Meals

Other Services *(select one)*	
X	Not applicable
○	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:

a.	
b.	
c.	
d.	
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services *(select one)*	
X	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(select one)*	
○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:	
a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	Background checks will be required for direct service provider employees who operate within the State of Alabama and who either provide direct services to the participant and/or who have access to client records. The state background checks will be conducted by the provider agency and will also include a reference check with previous employers and the Nurse/Aid Registry. Verification of investigations will be conducted during periodic audit reviews of the service providers by the OA.
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
X	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
X	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	(A) Services provided by relatives or friends may be covered only if relatives or friends meet the same qualifications as other direct care providers and are employed by an approved provider of service. Relatives who are providers of services cannot be a parent/guardian of a minor or spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be justification as to why the relative of friend is the provider of care and documentation in the case manager's file showing the lack of other qualified providers. (B) The strict controls to assure that payment is made to relatives or friends as providers in return for authorized services include the following:

	1) The relative or friend must be employed by a Direct Service Provider (DSP) Agency. 2) Meet the qualifications outlined in the scope of service as any other personal care, respite, homemaker, or companion worker employed by a DSP agency. 3) Complete a service log reflecting the type of service provided including the number of hours of service, the date and time of service. 4) Have the client/or representative sign the service log at each visit. If the relative or friend normally acts as a representative another individual must sign the service log. 5) The service log is reviewed by a DSP supervisor at least once biweekly. 6) Supervisory visits to the participant's residence at 60 day intervals. 7) Direct on-site supervision of the DSP worker providing the authorized service at least once every 6 months and more frequently if warranted. 8) Monthly visits by the case managers to address client satisfaction with the provision of services and to question the client confidentially about the adequacy of the services received and their needs are met as well as to observe the client or friend as services are provided. (C) While each service may be offered by a relative the state will ensure that no conflict of interest will occur because the relative providing the direct service will not be involved in the development of the care plan or allowed to sign service logs which serve as documentation that the authorized services have been provided when the participant is unable to do so. When the primary care giver or authorized representative for the participant must also act as the direct service provider worker another individual must be assigned the aforementioned responsibilities as well as assume responsibility for any other functions which could potentially result in a conflict of interest. The case manager must be available during the monthly visits to observe the provision of the direct service by the guardian and question the participant confidentially about their satisfaction with those services.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

When a prospective provider calls and expresses interest in providing waiver services, a contracting package is prepared; and mailed. After the package is returned it is reviewed for completeness of information. The OA will conduct an initial on-site visit to verify that the provider is in compliance with Medicaid Waiver standards and regulations before approval as a direct service provider is made. Every new provider is also required to attend a waiver training conducted by the OA.

When all information from the potential provider has been reviewed and verified, a financial amount is established and a contract is signed by the appropriate authorities. If the provider is not a certified home health agency, a letter is prepared requesting the Commissioner of the Alabama Medicaid Agency to exempt the provider from the certification requirement of the Elderly and Disabled Waiver based on the OA's review of the provider. Once the exemption is granted, the contract may be signed.

After the contract is finalized, the provider is mailed a confirmation letter

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Case Management**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Services may be used to locate, coordinate, and monitor necessary and appropriate services.

Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. Case Management is a waiver service available to all Elderly and Disabled (E/D) Waiver clients

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen minutes (15) beginning on the date that the client is determined eligible for E/D Waiver Services. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Employed by ADPH or ADSS contract with the Area Agency on Aging to provide Case Management.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person		Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Social Worker	Social Work		Earned the degree from an accredited School of Social Work
Registered Nurse	State of Alabama		License must be current

Bachelor of Arts or Bachelor of Science Degree	None	None	Preferably in a human services related field from an accredited college or university

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Social Worker	ADPH, and ADSS	Verified initially, and bi-annually thereafter
Registered Nurse	State Board of Nursing ADPH and ADSS	Verified Annually Verified Bi-annually
Bachelor of Arts or Bachelor of Science Degree	ADPH and ADSS	Verified initially

Service Delivery Method

Service Delivery Method *(check each that applies)*:	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Personal Care**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Personal Care services provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family. Personal Care Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct PC Service provided in the client's residence. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the client's plan of care. The amount of time authorized does not include the Personal Care Worker's transportation time to or from the client's residence, or the worker break or mealtime.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Medicare/Medicaid certified Home Health Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.

Specify whether the service may be provided by *(check each that applies):*	NO	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Care Worker	None	None	Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency. The Personal Care Worker is required to receive initial training/orientation before providing services. A minimum of twelve (12) hours of relevant in-service training

			per calendar year is also required.
Registered Nurse or Licensed Practical Nurse (in supervisory capacity)	Current license from the State of Alabama.	None	Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	**ADPH** **ADSS**	Verified initially and bi-annually thereafter.
Nursing Services	**ADPH, ADSS**	Verified initially and bi-annually thereafter.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Homemaker**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Homemaker Service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the Plan of Care. The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Contracted DSP Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Homemaker	None	None	Be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The

			workers must get a tuberculin skin test annually.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker	**ADPH, ADSS**	Verified initially and bi-annually thereafter
Homemaker Supervisor	**ADPH, ADSS**	Verified initially and bi-annually thereafter

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Respite Care**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.

The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 2880 units per waiver year (October 1-September 30) in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Contracted certified Home Health Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Registered	State of Alabama	None	A RN currently licensed by the Alabama

Nurse(RN) (Skilled Respite)			This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and have at least two (2) years experience as a RN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually. .
Licensed Practical Nurse((LPN) (Skilled Respite)	State of Alabama		This service will be performed by a Licensed Practical Nurse with an active license from the Alabama State Board of Nursing and have at least two (2) years experience as a LPN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually. The LPN must work under the supervision of an RN.
Respite Care Worker (Unskilled Respite)	None	None	This service will be performed by non licensed personnel who possess the ability to read and write, as well as the ability to work independently on an established schedule and can follow the plan of care with minimal supervision. Unskilled Respite Workers must meet the same orientation and in-service requirements as a Personal Care Worker and submit to a program for testing, prevention and control of tuberculosis.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	ADPH, ADSS	Verified initially and bi-annually thereafter
Licensed Practical Nurse	ADPH, ADSS	Verified initially and bi-annually thereafter
Respite Care Worker	ADPH, ADSS	Verified initially and bi-annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Adult Day Health**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service.

Adult Day Health is not an entitlement. It is based on the needs of the individual client.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time, lunch breaks or free time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Adult Day Health Center

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Director of Center	None	None	Have a high school diploma or equivalent; test for tuberculosis annually; and
Registered Nurse or Licensed Practical Nurse	Licensed by the Alabama Board of Nursing	None	At least two (2) years experience as a Registered Nurse or Licensed Practical Nurse in public health, hospital or long-term care nursing. Must submit to a program for the testing, prevention, and

			control of tuberculosis annually.
Adult Day Care Worker	Alabama Driver's License	None	Have a valid Alabama driver's license if transporting Adult Day Health clients; possess a valid, picture identification; all Adult Day Health Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Director of Center	ADPH, ADSS	Verified as Necessary
Registered Nurse or Licensed Practical Nurse	ADPH, ADSS	Verified as Necessary
Adult Day Care Worker	ADPH, ADSS	Verified as Necessary

Service Delivery Method

Service Delivery Method *(check each that applies)*:	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Companion Service**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct Companion Service provided to the client. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The maximum number of units that can be authorized may not exceed four (4) hours daily. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the client.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Contracted DSP, certified Home Health Agencies or other home health care agencies approved by the Commissioner of the Medicaid Agency.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Companion Worker	None	None	Complete a probationary period determined by the employer with continued employment contingent on completion of the initial training/orientation training program. All Companion Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Companion Worker Supervisor	ADPH, ADSS	Verified initially and bi-annually thereafter
Companion Worker	ADPH, ADSS	Verified initially and bi-annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	N/A	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Home Delivered Meals**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Home Delivered Meals are provided to an eligible individual age 21 or older who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

When specified in the Plan of Care, this service may include seven (7) or fourteen (14) frozen meals per week. A client may be authorized to receive seven (7) frozen meals plus seven (7) breakfast meals in lieu of fourteen (14) frozen meals. In addition, the service may include the provision of two (2) or more shelf-stable meals (not to exceed 6 meals per 6-month period) to meet emergency nutritional needs when authorized on the client's Plan of Care.

During times of the year when the state is at an increased risk of disaster from either hurricanes, tornados or ice/snow conditions, the meals vendor will be required to maintain at a minimum, a sufficient inventory to operate all frozen meals delivery routes for two days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid – approved Disaster Meal Services Plan. This plan will provide frozen meal alternates in anticipation of possible power outages.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual client and the unit(s) of service needed will be specified in the Plan of Care. The unit of service is one (1) package of seven meals. Each package of meals consist of (7) frozen meals or seven (7) breakfast meals. At least one unit of frozen meals may be delivered once a week to a client's residence. Additionally, a second package of seven (7) frozen meals or seven (7) breakfast meals can be provided as indicated on the Plan of Care. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the client's residence.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Contracted Vendor

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Registered Dietician	State of Alabama valid state license	None	Current dietician registration
Driver of delivery truck	Valid driver's license		Should receive initial and on-going training in the proper service, handling, and delivery of food.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meals Providers	State of Alabama	Verified initially and monitored on an on-going basis.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
X	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Plan of Care

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
	Licensed physician (M.D. or D.O)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Social Worker. *Specify qualifications:*
	Bachelor of Arts degree or a Bachelor of Science degree from an accredited School of Social Work
	Other (*specify the individuals and their qualifications):*
	Case Managers with a Bachelor of Arts or a Bachelor of Science degree preferably in a human related field.

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	Services and supports to clients are monitored directly by case managers on a monthly basis or as needed and peer reviews are done on an annual basis by ADSS. In addition, the Operating Agencies perform a review of the case managers' records at least every two months. The Operating Agencies also conduct random home visits to monitor service plan implementation and assess the health and welfare of clients. Annual desk reviews performed by the AMA Quality Improvement (QI) and Standards Division include case management personnel, client files, and to visit participants in their homes. A retrospective review is also conducted by the Long Term Care Admissions/Records Unit.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager, the client, family member or legal representative/other person designated by the client, meet to develop the plan of care. During the meeting, all parties may discuss the needs of the client; informal supports provided by the family and/or other community services to identify the gaps in support and are informed by the case manager of waiver services which may fill the gaps. Replacement services for these gaps will be addressed by the case manager of waiver services at this time. The participant decides which personal representative(s) will be involved in development of the plan of care.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The plan of care is developed as a part of the initial assessment for all applicants for available waiver services and revised periodically as the needs of the recipient change.

The plan of care is monitored monthly during the case manager's face-to-face visit, at redetermination annually and more frequently if the client's condition warrants a modification of the plan of care. When a plan of care is revised the client/and or their family member or legal representative must be issued a written notice at least 10 days in advance of any adverse actions that may result from the change.

When a participant is approved for EDW services and the POC is implemented or when changes are made to the plan of care, the case manager is responsible for contacting the Direct Services Provider (DSP) to discuss and coordinate the provision of services included in the plan of care. The case manager will seek a verbal approval or refusal to provide waiver services from the DSP. If the DSP agrees to provide services the case manager completes a service authorization form and sends this to the DSP along with a copy of the waiver application. The case manager must ensure that services requested on the service authorization form include only those services authorized in the POC. The DSP is also forwarded information about the specific needs and desires of the client as well as the specific task to be performed. When the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the POC, the DSP will contact the case manager to discuss authorization of additional services. Case managers are responsible for review and modification to the POC.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the participant's safety are addressed in the development of the plan of care. Plans are individualized and should take into consideration the participant's rights, values and preferences as related to any potential risks to health and safety. During the monthly face-to-face case management visit, the participant's health and welfare is reviewed, the plan of care adjusted accordingly and evaluated for appropriateness.

During the monthly visit the case manager assesses the home to ensure the participant is safe, questions the participant regarding satisfaction with services and providers, as well as makes observations to ensure the health needs are met, and notes any changes that may require modifications to the POC. The case manager also documents, addresses and monitors any health and safety concerns.

When the participant is considered "highly" at risk the case manager may visit more often to monitor the situation to ensure the participant's health and safety is not jeopardized. When a risk has been reported or identified, a home visit to monitor the health and safety of the client is required as soon as it can be arranged.

Additionally, DSP staff must visit the participant's home as ordered in the POC. DSPs are trained and expected to observe and report any concerns about a participant's health and welfare to the case manager and in writing to supervision of the DSP agency.

Direct Service Providers have policy/procedures established for serving clients in the event the assigned worker is unable to provide the service. As part of this back-up protocol the DSP's are notified of high risk clients so that any participant designated by the case manager as at risk should be given first priority when service visits must be temporarily prioritized and/or reduced by the DSP.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As the plan of care is developed the case manager discusses and documents the client's freedom to choose a direct service provider from the list of approved contract providers that are qualified, available and willing to provide the services. The case manager present a list of all qualified providers listed in alphabetical order for all waiver services available in the area. At the initial visit, a written choice should be made for each waiver service that the client desires to access.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The AMA will conduct a random sample of all plans of care for persons receiving waiver services. Medicaid QI Division reviews a sample of plans of care and related documents annually for providers, to assure that the clients receiving services under the waiver have a plan of care in effect for the period of time the services were provided. This review ensures that the need for services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

A copy of the plan of care is maintained by the case managers, service provider and in the client's home.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

O	Every three months or more frequently when necessary
O	Every six months or more frequently when necessary
X	Every twelve months or more frequently when necessary
O	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
	Operating agency
X	Case manager
	Other (*specify):*
	Direct Service Provider and the client's home

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The plan of care is monitored and reassessed by the OA case manager at least once a month during the face to face visit. In addition, the Operating Agencies perform a review of the case managers' records at least every two months. The Operating Agencies also conduct random home visits to monitor service plan implementation and assess the health and welfare of clients.

The client and or responsible person is encouraged to notify the case manager if services are not being provided as planned and if the client's needs or situation changes. The case manager identifies and promptly carries out needed changes in coordination with the client and or responsible person and other care providers. The plan of care is revised as needed to adapt to a client's changing needs.

Annual reviews of the AMA Quality Improvement (QI) and Standards Division staff also monitor case managers and client records for service implementation and following the plan of care annually and also ensure the plans of care are reviewed at least at the face to face visits monthly. During the review, incidents and complaints are reviewed to assure that they are addressed and resolved appropriately. They also visit client's in their homes to assure that health and safety are being met.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Services and supports to clients are monitored directly by case managers on a monthly basis or as needed. In addition, the Operating Agencies perform a review of the case managers' records at least every two months. The Operating Agencies also conduct random home visits to monitor service plan implementation and assess the health and welfare of clients.

Annual desk reviews performed by the QI Division include case management personnel files, client files, and visits to participants in their homes. A retrospective review is also conducted by the Long Term Care Admissions/Records Unit.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

O	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
X	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

O	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
X	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

O	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
O	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
O	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	☐ Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled as specified in Appendix C-3.	
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		☐ Assist participant in verifying support worker citizenship status
		☐ Collect and process timesheets of support workers
		☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

	☐	Other *(specify):*
	Supports furnished when the participant exercises budget authority:	
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:*
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
☐	Schedule staff
☐	Orient and instruct-staff in duties
☐	Supervise staff
☐	Evaluate staff performance
☐	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)

☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a. Description of the procedures by which eligible individuals or their representatives are informed of the feasible alternatives available under the waiver.

As part of assessment and service coordination visit, clients and/or responsible parties are provided with adequate information to make an informed decision regarding institutional and community based care. Service coordination addresses problems and presents feasible solutions.

Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

b. Following is a description of the State's procedures for allowing individuals to choose either institutional or home and community-based services

Each person served through the waiver makes a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the form and has no legal or responsible party who can sign. In such a situation, services will not be denied just because a written choice statement cannot be obtained. The case manager must carefully document the reason(s) for absence of a signed choice and the efforts to locate and encourage a responsible party who could have signed for the person.

c. Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the administering agency adversely affects his/her eligibility status or receipt of service. The formal process is in accordance with 42

C.F.R. Section 431, Subpart E and Chapter 3 (560-X-3) of the Alabama Medicaid Administrative Code. A Hearing Officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the case manager discusses proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/ representative.

Whenever there is a decision by the administering agency to reduce, suspend, or terminate waiver services to coincide with the person's current need or the person's loss of eligibility for the service, the Operating Agencies will issue a written 10 day advance notice to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E. A copy of the notice will be forwarded to the Medicaid Agency,

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

X	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
○	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Alabama Medicaid Agency does operate another dispute resolution process, the informal conference process, which offers participants the opportunity to appeal decisions that adversely affect their services, while preserving their right to a fair hearing. An individual choosing to use the informal conference to resolve a dispute is informed in writing by the case manager that if the informal conference decision is not favorable, they maintain their right to have a fair hearing.

At the conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the informal conference, the participant, applicant, or his/her legal representative can submit a written request for a fair hearing within sixty days of the date of the informal conference decision. The document referring to the participant's appeal rights is maintained in the waiver participant's home for future reference.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. Part 431 Subpart E for individuals who are still dissatisfied after the above procedure has been completed. A written request for a hearing must be filed within sixty (60) days following the action with which he/she is dissatisfied. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he/she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper,

Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

Regulations found at 42 CFR 431.222 allow the State to consolidate individual requests for a hearing into a single group hearing for cases where the sole issue involved is one of Federal or State law or policy. However, the state does offer a hearing in these cases. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

X	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The following State Agencies are responsible for the operation of the grievance/complaint system:

1. Alabama Department of Public Health(ADPH)
2. Alabama Department of Senior Services(ADSS)
3. Alabama Medicaid Agency(AMA)

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ADPH and ADSS are responsible for explaining the procedures to clients of filing complaints and grievances. ADPH and ADSS must also have procedures in place that will assure AMA that DSP have explained to clients the process on how to register a complaint. The DSP supervisor will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or AMA.

a. Complaints are submitted to ADPH, ADSS, or the AMA and are investigated through resolution. A tracking log will be used to document the incidents and resolutions of incident in the AMA's Quality Improvement (QI) and Standards Division. The OA will also maintain a log of complaints and grievances received.

b. If complaints are received by the AMA, a copy will be forwarded to ADPH or ADSS within two (2) working days. If they are received by ADPH or ADSS a copy will be forwarded to AMA LTC Program Management Unit within two (2) working days.

c. ADPH or ADSS must investigate all complaints upon receipt of notification. Appropriate parties must initiate action within 24 hours if it appears that a client's health and safety is at risk. If necessary the complainant will be interviewed.

d. A summary and plan of correction will be sent from the OA to the AMA QI and Standards Division for all complaints reported within 30 days of the request for the

summary or plan of correction from the AMA. The providers must forward their plan of corrections to the OA who will in turn forward to AMA. The AMA will evaluate the plan of correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the OA within two (2) days. The revised plan of correction will be resubmitted to the AMA within two (2) working days. If the summary or plan of correction carried out is found not to be responsive, the OA will have up to 45 days to revise the plan and carry out the appropriate action.

e. ADPH or ADSS will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risk exist.

f. Final determinations including any adverse findings will be reported to the AMA, LTC Program Management Unit.

g. The AMA will contact the client via telephone to ensure full resolution to the incident has been completed satisfactory.

h. ADPH or ADSS will forward all grievance logs to AMA, QI and Standards Division quarterly for review, tracking, and assurance that resolutions have been completed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Critical Event or Incident Requirements

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Death	Immediate
Exploitation	24-hours
Moderate Injury	24-hours
Major Injury	24-hours
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours

Definitions

Physical Abuse-the infliction of physical pain, injury or the willful deprivation by a care giver or other person of necessary services to maintain physical and mental health.

Sexual Abuse–any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include rape, incest, sodomy, and indecent exposure.

Verbal Abuse-the infliction of disparaging and angry outbursts such as name calling, blaming, or accusatory comments.

Neglect- the failure of a caregiver to provide food, shelter, clothing, medical services, or healthcare for the person unable to care for himself or herself; or the failure of the person to provide these basic needs for himself or herself when the failure is the result of the person's mental or physical inability.

Mistreatment-Actions that cause harm or create serious risk of harm whether intended or not, to a vulnerable person, by the caregiver or another person, or failure of a caregiver to satisfy the basic need or to protect the child or adult from harm.

Death-the permanent suspension of consciousness and the end of life.

Exploitation-the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

Moderate Injury-any observable and substantial impairment of a person's physical health such as temporary loss or impairment.

Major Injury-any observable and substantial impairment that results in permanent or temporary impairment, such as fractures, injury to internal organs, burns, or physical disfigurement of the body. These injuries may result in hospitalization.

Natural Disaster-the consequence of the combination of a natural hazard such as tornadoes, hurricanes, floods, power outages and winter weather.

Fire– a situation in which something such as a building or an area of land is destroyed or damaged by burning.

Fall- an incident that causes a person to drop suddenly from an up-right position which may result in harm.

All Medicaid approved providers who provide home and community-based services in Medicaid recipient's homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

The Alabama Adult Protective Services Act of 1976 outlines the specific responsibilities of the Department of Human resources, law enforcement authorities, physicians, caregiver's individuals and agencies in reporting and investigating such cases, and in providing the necessary services.

Alabama Code §§ 38-9-1-11 Adult Protective Services Act of 1976

All physicians, osteopaths, chiropractors and caregivers are required by law to report instances of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that an adult has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the Adult Protective Services Hotline (1800-458-7214).

Other incidents such as falls must be reported within 24 hours to the Provider Agency, the Alabama Medicaid Agency, the Alabama Department of Public Health and the Alabama Department of

Senior Services in a timely manner based upon the circumstances surrounding the incident.

Child Abuse Prevention and Treatment Act 1974

Alabama law is clear on reporting abuse and neglect of children under the age of 18. For example, physicians, teachers, social workers, nurses, day care workers or anyone who comes in contact with suspected child abuse or neglect should make a report to those who can take action. An oral report, either by telephone or in person must be made immediately if there is reasonable cause to believe that a child has been subjected to abuse, neglect, or exploitation, followed by a written report to the chief of police or sheriff, the County Department of Human Resources or the State Child Abuse Reporting Hotline (334- 242-9500).

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case manager and the direct service provider are responsible for ensuring that the participants, and/families or legal representatives are informed about their rights concerning abuse, neglect and exploitation at least annually. Case managers maintain relationships with consumers to encourage them to talk about what is important to them as well as what they do not like. Each recipient is informed of his/her rights and responsibilities during the initial assessment. The legal guardian and/or advocate is informed of the recipient's rights, responsibilities, protections or means to enforce the protections, if the recipient is not able to understand. The case manager and the DSP is responsible for informing the client/or responsible party of their right to lodge a complaint and how to register a complaint alleging abuse, neglect/ or exploitation.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Alabama Department of Public health and the Alabama Department of Senior Services are the entities that receive reports of critical events or incidents. Each operating agency (OA) will investigate the critical events reported and make a decision within seven (7) working days. If a decision cannot be reached, additional information is requested. Resolution is reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved. All allegations of abuse require an investigation. If the OA determines that an incident requires follow-up, the Case Manager will monitor the situation and make referrals to the appropriate reporting agency or follow-up on referrals previously made to ensure that the issue has been satisfactorily resolved. If other services or supports are needed to resolve the situation, the Case Manager will seek available resources and arrange when appropriate. Responses to the critical events or incidents are appropriately coordinated and assigned with a completion date not to exceed 30 days based on the nature of the incident.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Alabama Department of Public Health and the Alabama Department of Senior Services are responsible for overseeing the reporting of and response to critical incidents or events that affect

waiver participants through individual/family interviews. The operating agency will notify Medicaid's E & D Waiver Coordinator of critical incidents and events as they occur and any follow-up action taken. In addition, Medicaid's Quality Improvement and Standards Division is responsible for overseeing the reporting of and response to critical incidents through review of quarterly participation satisfaction surveys, review of complaint logs, medical record reviews, DSP personnel record reviews as well as annual onsite home and provider visits.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

X	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
	The Alabama Department of Public Health (ADPH): Monthly monitoring of participants health and welfare and provider quality reviews. The Alabama Department of Senior Services (ADSS): Monthly monitoring of participants health and welfare and provider quality reviews. The Department of Human Resources (ADHR): certain incidents of abuse, neglect and exploitation must be reported to ADHR by law. The Alabama Medicaid Agency: Annual review of ADPH and ADSS investigations.
○	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

X	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
	The Alabama Department of Public Health an the Alabama Department of Senior Services are responsible for detecting the unauthorized use of restrictive interventions through monthly face to face visits as well as supervisory visits every 60 days.

○	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
X	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
X	Not applicable (*do not complete the remaining items*)

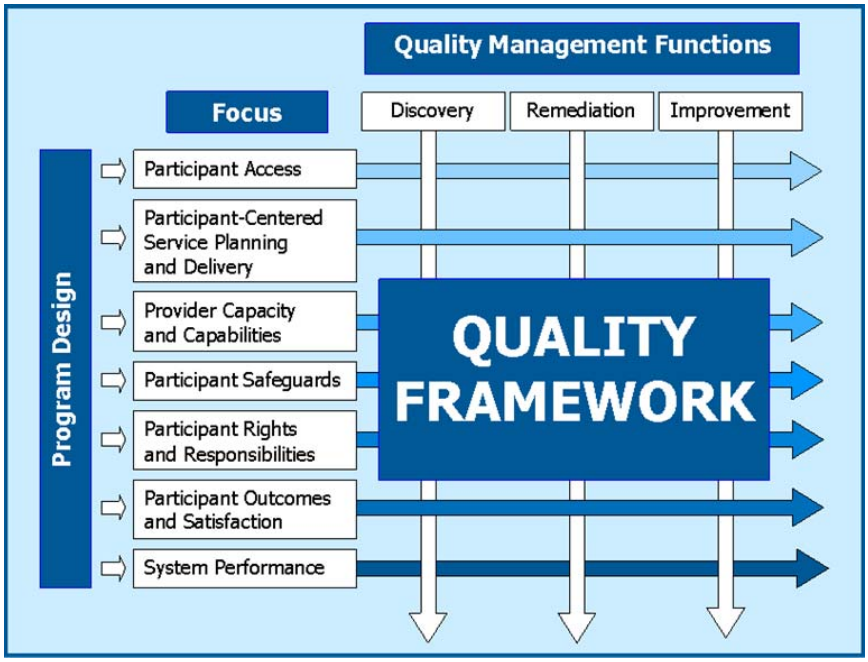
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and

The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Description of the Quality Management Program for the Elderly and Disabled Waiver

The Quality Management Strategy for the Elderly and Disabled (E & D) is:

Alabama Medicaid's Quality Improvement and Standards Division is responsible for collecting data quarterly and annually regarding the quality of services provided from various sources for the E & D Waiver program. The Quality Framework is used as a guide to assess seven (7) Program Design Focus areas from samples of waiver participants, case management and direct service providers' records, on-site home visits, and onsite visits to adult day health facilities. In addition, consumer satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine clients' satisfaction with resolutions.

Data is collected through annual review of each operating agency's policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a 5% audit of all applicants approved by the AMA is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. 5% of the waiver population is chosen for record review to ensure coordination of care, quality care, outcomes and billing accuracy. Personnel records of 5% case managers and 5% of other employees' personnel records are reviewed to ensure basic and continuing education requirements are met. Home visits are made to 2% of the clients annually to ensure quality care, health and safety, ongoing needs are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months until they are found to be in compliance.

The collected data is reported quarterly and annually to each operating agency and to Medicaid's LTC Project Development/Program Support Unit for evaluation and recommendation for improvements to the program. The Medicaid's LTC Division is the authority for operating the Waiver Program; therefore, recommendations for improvements will be evaluated by the LTC Division for final determination of changes to the program.

In order to measure and improve performance, data is collected, reviewed and reported using the seven focus areas of the Quality Framework.

Participant Access:

Sources of data

Case Management Records
Home Visits
DSS Queries
Consumer Surveys

Participant –Centered Service Planning and Delivery:

Sources of data

Consumer Surveys
Case Management Records
Site Visits
Home Visits

Provider Capacity and Capabilities:

Sources of data

Consumer Surveys
Case Management Records
Personnel and Training Records of Operating Agency and Subcontractors
Home Visits

Participants Safeguards:

Sources of data

Case Management Records
Consumer Surveys
Home Visits
Site Visits

Participants Rights and Responsibilities:

Sources of data

Consumer Surveys
Case Management Records
Complaint and Grievances Logs
Targeted Surveys

Patient Satisfaction:

Sources of data

Consumer Surveys
Case Management Records
Home Visits
Site Visits

System Performance:

Sources of data

Review of Operating Agency Quality Assurance System
Review of Operating Agency Billing and Service Provision
Collaborated Meeting with Operating Agency to enhance the administration of the Program
Subcontractor Client Records

The following indicators are reported to the operating agencies and Medicaid's Long Term Care Division:

- Percentage of client/family reporting satisfaction with waiver services and needs met.
- Percentages of client/family reporting they feel safe and secure in the home and community.
- Percentage of client/family reporting they have ready access to services and were informed of sources of support available in the community.
- Percentage of client/family reporting knowledge of rights and responsibilities.
- Percentage of records indicating services are planned and implemented according to the client's needs and preferences.
- Evidence that each operating agency has a Quality Assurance System in place that monitors subcontractors.
- Evidence that each operating agency has a system in place to ensure only qualified providers are enrolled, credentials are verified and training of personnel is ongoing.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medicaid's post-payment financial audit program for the E & D Waiver is designed to ascertain that only reasonable and allowable expenses are included in the cost reports received from the operating agencies. Cost reports are due to Medicaid no later than 90 days after the fiscal year end. An audit of the cost reports is conducted annually. These audits are limited in scope. The basis for the audit is a comparison of Medicaid's adjudicated claims file to the provider's cost report. The auditor will conduct a sampling process of the provider's expenditures. The sample includes, but is not limited to; provider contracts, cost allocation, previous audits, cash disbursements, general ledger accounts, cash receipts, verification of deposits, payroll records including employee time sheets and cancelled checks, vendor invoices, and all vouchers or revenues received from Medicaid. All records must be capable of audit verification. Any expenses the auditor is unable to verify will be disallowed. If an independent audit of the OA has been performed, Medicaid will rely on the independent auditor's findings and opinion regarding compliance and internal control. After the sample is completed, the auditor will make adjustments to the cost report if necessary. The provider's adjusted cost report is compared to Medicaid's paid claims file for final settlement.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates for E & D Waiver services are established by Medicaid. They are prospective rates that are based on audited historical costs with consideration given to the health care index and renegotiated contracts. Medicaid pays private and public contractors the same rate. An OA may request an interim increase or decrease at any time. If approved by Medicaid, the adjusted rate allows claims to be paid at a rate that is closer to the provider's actual cost. If a rate adjustment is retroactive, previously paid claims are recouped and repaid at the adjusted rate. At fiscal year end, the total amount paid by the OA is divided by the total number of units served, and an average rate per service is determined. Medicaid uses the average rate to determine the final settlement.

For each waiver service, a HCPC code is determined with a rate assigned to each code. The Medicaid Management Information system (MMIS) pays the claim based upon the State's determined pricing methodology applied to each service by provider type, claim type, recipient benefits and policy limitations. All claims submitted for adjudication must pass certain edits in the MMIS. Once a claim passes through edits, the system reviews each claim to make sure it complies with AMA policies. The MMIS then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compare them to Alabama Medicaid policy to ensure that recipient benefits are paid according to current policies.

As each waiver year is audited, this cost like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost. Cost Reports from the OAs are due to Medicaid by December 31. Cost settlements are made no later than September 30 of the following year.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Each waiver participant, once approved, is added to the Alabama Medicaid's Long Term Care File. This file holds approved dates of eligibility for waiver services.

Providers billings flow directly from the providers to the Medicaid MMIS through Electronic Data System (EDS), the Fiscal Intermediary as follows:

- Payments made by Medicaid to providers are on a cost reimbursement basis. Each covered service is identified on a claim by a HCPC code.
- For each recipient, the claim allows span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. Each service type is identified by Procedure Code and will include all units of that service provided during that month. Specific dates for each unit can be identified on the Service Authorization Form.
- If the submitted claims covers dates of service where part, or all of which were covered in

a previously paid claim is rejected. The provider is required to make the corrections on the claim and resubmit for processing.

- Payment is based on the number of units of service reported on the claim for each procedure code.
- Accounting for actual costs and units of services provided during the waiver year, are captured on the CMS 372 Report.
- All claims must be filed within twelve months from the date of service. Medicaid recovers payments that exceed actual allowable cost.
- Payment is based on the number of units of service reported on a claim for each procedure code. There is a clear differentiation between waiver services and non-waiver services and a clear audit trail exists from point of service through billing and reimbursement.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
	☐ **Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐ **Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
X	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The system performs validation edits to ensure the claim is filled out correctly and contains appropriate information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the HCPC code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met. For electronically submitted claims, the edit process is performed several times per day. For paper claims, it is performed five (5) times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews the claim history information against information on the current claim. Audits check for duplicate services, service limitation, and related services and compare them to Alabama Medicaid policy. The system then prices the claim using the State –determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claim processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by EDS personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the check writing schedule published by the Alabama Medicaid Agency. The check is sent to the provider's payee address with an EOP, which also identifies all denied claims, pending claims, and adjustments. If the provider is enrolled in the electronic funds (EFT) transfer process, the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

X	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

X	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal

financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

X	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	The Alabama Department of Public Health and Alabama Department of Senior Services are the operating agencies for the E/D Waiver. These state agencies provide EDW services such as: case management, personal care, homemaker, etc.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

X	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

○	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
X	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
	Medicaid bills ADPH and ADSS the non-federal share plus a 1% administrative fee. The Alabama Medicaid Agency does not return any portion of the 1% administrative fee to CMS.
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

X	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	ADPH and ADSS
○	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

X	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	The ADPH, ADSS, and the thirteen Area Agencies and other providers of waiver services all provide one or more Medicaid service and are eligible to be OHCDS. Providers may enroll directly with the Medicaid Agency if they wish. Free choice of providers is assured by the policies and procedures in effect and practices carried out are case managers. All providers are certified and monitored by Quality Assurance reviews performed by ADPH, ADSS or Medicaid. All subcontractors are submitted to the state

	for review of applicable provisions.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
X	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	The source of non-federal funds for the HCBS Waiver for the Elderly and Disabled Waiver is the general fund appropriations to ADPH and ADSS. These funds are 106, general fund; 349, other funds such as federal, intergovernmental transfers, drug rebates, and other small amounts; 564, Health Care Trust Funds for provider taxes; and 1047, tobacco revenue. These funds are for the sole use of Medicaid once the appropriation is made by the Legislature. The Alabama Legislature does not line item budget any revenue or expenditure for Medicaid. In other words, no revenue comes to Medicaid earmarked for certain expenditures. It is up to Medicaid how a voucher is coded and thus charged. If Medicaid has any balance in fund 106 at the end of the year, it does not revert back to the State general fund.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

X	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

X	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.	
○	The following source (s) are used. *Check each that applies.*	
	☐	Provider taxes or fees
	☐	Provider donations
	☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:	
	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

X	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
O	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			NH				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	9,659	11,627	21,286	31,413	2,510	33,923	12,637
2	10,009	12,046	22,055	32,544	2,601	35,145	13,090
3	10,368	12,480	22,848	33,716	2,694	36,410	13,562
4	10,742	12,929	23,671	34,930	2,791	37,721	14,050
5	11,130	13,394	24,524	36,186	2,892	39,078	14,554

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	
Year 1	9205	9205	
Year 2	9205	9205	
Year 3	9205	9205	
Year 4 (renewal only)	9205	9205	
Year 5 (renewal only)	9205	9205	

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Average length of stay is derived by dividing the total number of days in a waiver year by the total number of clients served. This information is based on data in the CMS-372 Report for year 10/01/2005-09/30/2006.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from data shown by the CMS-372 Report, Waiver #0068.91.R2, for Waiver Year 2006, with a 3.6 percent inflation factor applied to each year of the renewal period.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1(10/01/2007-09/30/2008)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	15 min	9205	144	$15.28	$20,253,945.60
Personal Care	15 min	5339	664	$4.41	$15,642,736.10
Homemaker	15 min	6996	896	$4.49	$28,113,845.76
Respite Care (Skilled)	15 min	368	1152	$5.67	$2,402,657.28
Respite Care (Unskilled)	15 min	1933	1052	$4.24	$8,622,107.84
Adult Day Health	Day	368	127	$18.25	$852,932.00
Companion	15 min	4603	480	$3.97	$8,765,953.20
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	$26.58	$1,272,969.36
Frozen Meals**	14 meals per week	921	104	$26.58	$2,545,938.72
Breakfast Meals	7 meals per week	644	52	$12.03	$402,860.64
Shelf Stable Meals	2 annually	2485	2	$7.29	$36,231.30
GRAND TOTAL:					$88,912,177.80
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					$9,659.12
AVERAGE LENGTH OF STAY ON THE WAIVER					277

Waiver Year: Year 2(10/01/2008-09/30/2009)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	15 min	9205	144	$15.83	$20,982,981.60
Personal Care	15 min	5339	664	$4.57	$16,201,088.72
Homemaker	15 min	6996	896	$4.65	$29,132,463.36
Respite Care (Skilled)	15 min	368	1152	$5.87	$2,489,564.16
Respite Care (Unskilled)	15 min	1933	1052	$4.40	$8,947,470.40
Adult Day Health	Day	368	127	$18.91	$883,777.76
Companion	15 min	4603	480	$4.11	$9,080,798.40
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	$27.54	$1,318,945.68
Frozen Meals**	14 meals per week	921	104	$27.54	$2,637,891.36
Breakfast Meals	7 meals per week	644	52	$12.46	$417,260.48
Shelf Stable Meals	2 annually	2385	2	$7.56	$37,573.20
GRAND TOTAL:					$92,129,815.12
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					$10,008.67
AVERAGE LENGTH OF STAY ON THE WAIVER					277

Waiver Year: Year 3(10/01/2009-09/30/2010)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	15 min	9205	144	$16.40	$21,738,528.00
Personal Care	15 min	5339	664	$4.74	$16,794,892.30
Homemaker	15 min	6996	896	$4.82	$30,182,423.04
Respite Care (Skilled)	15 min	368	1152	$6.09	$2,579,650.56
Respite Care (Unskilled)	15 min	1933	1052	$4.55	$9,252,497.80
Adult Day Health	Day	368	127	$19.59	$915,558.24
Companion	15 min	4603	480	$4.26	$9,406,690.80
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	$28.53	$1,366,358.76
Frozen Meals**	14 meals per week	921	104	$28.53	$2,732,717.52
Breakfast Meals	7 meals per week	644	52	$12.91	$432,330.08
Shelf Stable Meals	2 annually	2485	2	$7.83	$38,915.10
GRAND TOTAL:					$95,440,562.20
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					$10,368.34
AVERAGE LENGTH OF STAY ON THE WAIVER					277

Waiver Year: Year 4 *(renewal only)* (10/01/2010-09/30/2011)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	15 min	9205	144	$16.99	$22,520,584.80
Personal Care	15 min	5339	664	$4.91	$17,397,558.62
Homemaker	15 min	6996	896	$4.99	$31,263,724.80
Respite Care (Skilled)	15 min	368	1152	$6.31	$2,672,916.48
Respite Care (Unskilled)	15 min	1933	1052	$4.72	$9,598,195.52
Adult Day Health	Day	368	127	$20.30	$948,740.80
Companion	15 min	4603	480	$4.41	$9,743,630.40
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	$29.56	$1,415,687.52
Frozen Meals**	14 meals per week	921	104	$29.56	$2,831,375.04
Breakfast Meals	7 meals per week	644	52	$13.37	$447,734.56
Shelf Stable Meals	2 annually	2485	2	$8.11	$40,306.70
GRAND TOTAL:					$98,880,455.24
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					$10,742.04
AVERAGE LENGTH OF STAY ON THE WAIVER					277

Waiver Year: Year 5 *(renewal only)* (10/01/2011-09/30/2012)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	15 min	9205	144	$17.60	$23,332,465.80
Personal Care	15 min	5339	664	$5.09	$18,026,813.16
Homemaker	15 min	6612	896	$5.17	$32,392,039.68
Respite Care (Skilled)	15 min	368	1152	$6.53	$2,769,361.92
Respite Care (Unskilled)	15 min	1933	1052	$4.89	$9,943,893.24
Adult Day Health	Day	368	127	$21.03	$982,895.47
Companion	15 min	4603	480	$4.57	$10,097,140.80
Home Delivered Meals					
Frozen Meals*	7 meals per week	921	52	$30.62	$1,466,453.04
Frozen Meals **	14 meals per week	921	104	$30.62	$2,932,906.08
Breakfast Meals	7 meals per week	644	52	$13.86	$464,143.68
Shelf Stable Meals	2 annually	2485	2	$8.40	$41,748.00
GRAND TOTAL:					$102,449,860.87
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					9205
FACTOR D (Divide grand total by number of participants)					$11,129.81
AVERAGE LENGTH OF STAY ON THE WAIVER					277

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	Col. 6 **Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						